

**STATE OF CALIFORNIA  
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE  
GENERAL FRAMEWORK FOR PUBLIC HEARINGS**

At the April 22, 1997 Task Force meeting, Task Force members agreed to each submit several questions to the Chairman and Executive Director for the purposes of helping to guide their planning of future public hearings and Task Force meetings. This document provides a general framework for our hearings [I] and a compilation of the questions submitted by Task Force members to help guide our speakers in their presentation [II].

This document serves to assist the Task Force in obtaining constructive information/responses from members of the public and scheduled presenters at both our regular business meetings and public hearings. It is not binding and does not preclude Task Force members from asking additional or different questions.

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**[I] GUIDELINES FOR PRESENTATIONS TO THE TASK FORCE:**

**Background:** This Task Force was created by legislation authored by Assemblyman Bernie Richter, adopted unanimously by the Legislature and signed into law by Governor Pete Wilson in the autumn of 1996 to analyze the historical development and impacts of managed health care in California, as well as to recommend possible improvements by January 1, 1998.

In his initial charge to the Task Force, **Governor Wilson encouraged “further streamlining of and improving of government’s role in oversight and regulation, while preserving managed care’s best features: coordinated teams of highly skilled professionals delivering cost-efficient, patient-sensitive care based on the best clinical information science has to offer.”**

The majority of the working insured population in California is covered by managed care plans. The term “managed care” spans a broad spectrum of coverage types (including closed-panel provider HMO models as well as less restrictive models that allow more choice of providers). Generally, the more restrictive the choice of providers, the less expensive the health coverage. **Managed health care** involves a form of health care financing that relies in part on selective contracts between insurers and providers, as well as some utilization and quality management.

**The Managed Care Spectrum:**

**Health Maintenance Organizations** [HMOs] are managed care organizations that typically offer a comprehensive set of benefits, contract with purchasers on the basis of a fixed periodic rate per person with *payment in advance*, share some risk with the providers with whom they contract, and only pay for care when patients use the contracted providers (with some exceptions). HMOs are governed by the Knox-Keene Act in California, and are primarily regulated by the Department of Corporations. **Preferred provider insurance** [commonly known as preferred provider organizations or PPOs] is a form of indemnity managed care in which the insurers negotiate discounted fees with a select group of providers who agree to accept the fees negotiated as payment in full from contracting patients and create incentives for patients to choose contracting providers but still pay (although at a lower percent of fees) for care when consumers choose not to use the contracted providers. PPOs are regulated by the Department of Insurance.

In response to consumer desires for more choice in selecting providers, many hybrids of managed care models are currently developing. One example of a hybrid model is a **Point of Service (POS)** Health Maintenance Organization which provides consumers the option to go to providers outside of the contracted pre-paid HMO network if they are willing to pay for a percentage of the care received from non-contracted providers, essentially through an indemnity opt-out of a closed panel model. Many other coverage models, such as Exclusive Provider Organizations, are developing as the market evolves.

### **Notes to presenters and members of the public:**

We want to hear from you about your concerns, your positive comments and most importantly, your suggestions for improvements in the managed health care system. We would appreciate your balanced appraisal of the advantages and disadvantages of the existing system.

**Members of the public we want to hear from you, whatever your concern or suggestion, even if you cannot answer the following questions. However, you might find the following questions helpful to keep in mind as you formulate your thoughts for discussion with the Task Force.**

**If you are formally presenting to the Task Force, please be prepared to answer the following questions:**

- Do you have specific suggestions for improving managed care?
- Are your concerns or comments related to health insurance in general, or one or more forms of managed care specifically?
- Do your concerns or comments reflect systemic issues or individual examples?
- Do you have data available that supports your points?
- Can you identify the root cause of your concerns or comments?
- If you could make three changes in managed care, what would they be to help make managed care better for you and your fellow Californians?

We are most interested in your specific recommendations for changes to the system that would fix any problems that you raise or foster any benefits you describe.

We look forward to hearing from you and working with the public to improve our health care system.

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**[II] TASK FORCE MEMBERS SPECIFICALLY EXPRESSED AN INTEREST IN THE FOLLOWING QUESTIONS. These questions could be posed by members, as appropriate, to presenters of information.**

### **Health System Refinements:**

- If you are a member of a managed care plan, what do you value most that you would not want to have changed?
- What would you like to change most in the present health care delivery system?
- What, if any, is your greatest frustration with the current health care delivery system?
- What are HMOs not doing well in health care and what can they do to improve their performance? What about for other types of managed care?
- There is always a cost for the provision of services, are you willing to accept increases in health care costs for improved access to providers and better measurement of quality care?
- Do you believe that people should pay higher prices for coverage if they are sick? If you are a healthy person how much are you willing to subsidize people who are not healthy?

### **Access/Benefits Availability**

- What, if any, difficulties have you had in obtaining approval for medical care from your insurer or HMO?
- Are the health benefits available in your health coverage adequate? If not, what are the deficiencies?
- How could managed care health plans improve their responsiveness to consumers?
- Are the hours when your health care providers are available and /or the location of your provider a significant problem for you ?
- How much are you willing to spend on health insurance? If prices go up when do you choose not to purchase coverage?
- Do you feel all Californians have a right to medical care? If yes, who should bear the burden of payment for the uninsured, [e.g., all California taxpayers, individuals who can afford it but don't purchase it, or any specific group]?
- Do you think that long-term care should be included in your health coverage? (It would come into effect should a seriously disabling condition or terminal illness become incapacitating such that help is needed with such activities of daily living as eating, taking medications, bathing, etc.)
- Who has the obligation to subsidize coverage for the uninsured? Insured individuals? Small Employers? The Government?

### **State Role/ Regulatory Oversight and Organization:**

- What is the most appropriate role for the State of California in regulating or helping incent market self-regulation to achieve access by Californians to high quality health care at affordable prices?
- What role should state government in monitoring health care providers and managed care organizations? In particular, if you believe that government should play a role, what aspects would you want the government to monitor and regulate? Areas might be providing clinically appropriate, up-to-date care, financial solvency, access to care, dispute resolution, benefit language, advertising and consumer information materials, and ensuring delivery of certain services.
- What is state government doing well in its regulation of HMOs?
- In what ways could state government regulation of HMOs be improved?
- What government agency should regulate HMOs and insurers? Medical Groups? Providers (doctors, nurses, acupuncturists, etc.)?

### **Improving Quality / Increasing Information**

- There is a lot of talk today about quality of care in managed care. From your perspective, what does it mean to have a quality of care in managed care? From your perspective, what does it mean to have a quality health plan?
- What information, not now available, would be most useful to you in helping choose a health plan that best meets your needs?

- Do you think that standardized benefits packages would be helpful in comparing health coverage?
- Many believe that consumers need more information about medical quality-of-care to make informed choices about different health plans, hospitals, and physicians. However, reporting more extensively on medical quality would require the state to develop databases for meta-analysis that include confidential information about individuals' medical histories. Would you be willing to give the state government permission to develop such a database if proper safeguards for protecting confidentiality were applied if you knew you could get better information about the quality of medical care delivered by doctors, hospitals and health plans for purposes of comparison and public health improvement?

**For employers:**

- What approaches might be most useful to consider in providing choices to employees in their health coverage?
- How desirable is it for you to have the ability to purchase all of your health plans from one carrier?
- As compared to indemnity coverage, how beneficial have managed care products been in keeping your health benefit costs under control?
- How important is it for you to have the right to purchase a product under ERISA, that is, outside of the state regulatory framework? Why?

**For medical groups and health plans:**

Have you experimented with financial incentives that have resulted in higher patient satisfaction ratings and/or improved clinical outcomes? If so, could you describe?

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